

Aaron K. Potratz, LPC MA CADC-I
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Authorization for Release of Information

I, _____, authorize Aaron K. Potratz, to release/exchange
the following information to/with _____ at _____;
title(s)/name agency/organization
contact info (phone, fax, address)_____.

Please INITIAL yes or no for each line that applies:

<u>Yes</u>	<u>No</u>	Information to be released:
___	___	Medical Records, Results and/or Recommendations
___	___	Legal History Reports
___	___	Result and/or Recommendations of Evaluation/Assessment
___	___	Treatment Progress Report
___	___	Mental Health Diagnosis or Treatment
___	___	Alcohol, Drug, or Gambling Diagnosis or Treatment (according to 42 CFR Part 2)

Please INITIAL yes or no for each line that applies:

<u>Yes</u>	<u>No</u>	The purpose or need for such release is:
___	___	Facilitate Evaluation/Assessment Process
___	___	Facilitate Treatment Planning
___	___	Coordinate Client Services
___	___	Determine Eligibility
___	___	Emergency Contact

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.).

Signature of Client/Participant _____ Date _____

Signature of Parent/Guardian/or
Authorized Representative (if required) _____ Date _____

Signature of Therapist/Witness _____ Date _____